

		FOR OFF USE				

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0046615</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER														
Facility Name: <u>Flora Rehabilitation & Health Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.														
Address: <u>232 Given Street</u> <u>Flora</u> <u>62839</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.														
County: <u>Clay</u>																
Telephone Number: <u>(618) 662-8381</u> Fax # <u>(618) 662-8231</u>																
IDPA ID Number: <u>743055934009</u>																
Date of Initial License for Current Owners: <u>12/17/2004</u>																
Type of Ownership:																
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input checked="" type="checkbox"/> PROPRIETARY														
<input type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual														
<input type="checkbox"/> Trust		<input type="checkbox"/> State														
IRS Exemption Code _____		<input type="checkbox"/> Partnership														
		<input type="checkbox"/> Corporation														
		<input type="checkbox"/> County														
		<input type="checkbox"/> Other _____														
		<input checked="" type="checkbox"/> "Sub-S" Corp.														
		<input type="checkbox"/> Limited Liability Co.														
		<input type="checkbox"/> Trust														
		<input type="checkbox"/> Other _____														
In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-4581</u> Please send copies of desk review and audit adjustments to address on this page		<table border="1"> <tr> <td rowspan="2"> Officer or Administrator of Provider </td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2"> Paid Preparer </td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td rowspan="6"> SEE ACCOUNTANTS' COMPILATION REPORT </td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	SEE ACCOUNTANTS' COMPILATION REPORT	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
Officer or Administrator of Provider	(Signed) _____															
	(Date) _____															
Paid Preparer	(Type or Print Name) _____															
	(Title) _____															
SEE ACCOUNTANTS' COMPILATION REPORT	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>															
	(Date) _____															
	(Print Name and Title) _____															
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SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Flora Rehabilitation & Health Care Center# 0046615 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>32</u>	Skilled (SNF)	<u>32</u>	<u>11,680</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>67</u>	Intermediate (ICF)	<u>67</u>	<u>24,455</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,058</u>	<u>5</u>	<u>7,567</u>	<u>8,630</u>	8
9	SNF/PED					9
10	ICF	<u>15,069</u>	<u>6,090</u>		<u>21,159</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,127</u>	<u>6,095</u>	<u>7,567</u>	<u>29,789</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.44%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location

Date started 12/17/2004

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 12/17/2004NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 32 and days of care provided 7,567Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year

YES ☒NO ☐Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	158,491	16,253	1,412	176,156		176,156	3,583	179,739		1
2	Food Purchase		128,769		128,769		128,769	(6,149)	122,620		2
3	Housekeeping	86,482	30,185		116,667		116,667	84	116,751		3
4	Laundry	43,455	19,215		62,670		62,670	6	62,676		4
5	Heat and Other Utilities			98,838	98,838		98,838	592	99,430		5
6	Maintenance	37,233	33,183	1,540	71,956		71,956	5,700	77,656		6
7	Other (specify):* Home Office Benefits							1,219	1,219		7
8	TOTAL General Services	325,661	227,605	101,790	655,056		655,056	5,035	660,091		8
	B. Health Care and Programs										
9	Medical Director			31,200	31,200		31,200		31,200		9
10	Nursing and Medical Records	1,233,075	298,173	1,405	1,532,653		1,532,653	21,779	1,554,432		10
10a	Therapy			484,064	484,064		484,064	4	484,068		10a
11	Activities	35,082	13,228		48,310		48,310	11	48,321		11
12	Social Services	66,679	593		67,272		67,272		67,272		12
13	CNA Training										13
14	Program Transportation	374			374		374		374		14
15	Other (specify):* Home Office Benefits							4,596	4,596		15
16	TOTAL Health Care and Programs	1,335,210	311,994	516,669	2,163,873		2,163,873	26,390	2,190,263		16
	C. General Administration										
17	Administrative	92,714		170,000	262,714		262,714	(144,622)	118,092		17
18	Directors Fees										18
19	Professional Services			7,137	7,137		7,137	13,589	20,726		19
20	Dues, Fees, Subscriptions & Promotion			2,730	2,730		2,730	3,952	6,682		20
21	Clerical & General Office Expense	41,747	8,940	22,144	72,831		72,831	74,050	146,881		21
22	Employee Benefits & Payroll Tax			274,267	274,267		274,267	2,683	276,950		22
23	Inservice Training & Education			525	525		525	1,081	1,606		23
24	Travel and Seminar			2,048	2,048		2,048	1,045	3,093		24
25	Other Admin. Staff Transportation			12,942	12,942		12,942	4,639	17,581		25
26	Insurance-Prop.Liab.Malpractice			57,420	57,420		57,420	2,392	59,812		26
27	Other (specify):* Home Office Benefits							16,699	16,699		27
28	TOTAL General Administration	134,461	8,940	549,213	692,614		692,614	(24,492)	668,122		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,795,332	548,539	1,167,672	3,511,543		3,511,543	6,933	3,518,476		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Flora Rehabilitation & Health Care Center

#0046615

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			180,597	180,597		180,597	(42,908)	137,689			30
31	Amortization of Pre-Op. & Org											31
32	Interest			202,777	202,777		202,777	17,215	219,992			32
33	Real Estate Taxes			51,725	51,725		51,725	29	51,754			33
34	Rent-Facility & Grounds							589	589			34
35	Rent-Equipment & Vehicle			13,060	13,060		13,060	144	13,204			35
36	Other (specify): ³											36
37	TOTAL Ownership			448,159	448,159		448,159	(24,931)	423,228			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:		12,971		12,971		12,971		12,971			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify): ³ Nonallowable Cost			77,397	77,397		77,397	(77,397)				43
44	TOTAL Special Cost Centers		12,971	131,600	144,571		144,571	(77,397)	67,174			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,795,332	561,510	1,747,431	4,104,273		4,104,273	(95,395)	4,008,878			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Flora Rehabilitation & Health Care Center# 0046615

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(2,426)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(56,685)	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,123)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(535)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(55,240)	43		24
25	Fund Raising, Advertising and Promotiona	(3,538)	43		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employee				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule See page 5a	(18,732)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (138,280)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	42,885		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 42,885		36
37	(sum of SUBTOTALS (A) and (B))	\$ (95,395)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport		x	\$		38
39						39
40	Gift and Coffee Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Flora Rehabilitation & Health Care Center

ID# 0046615

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Labs - Part A	\$ (11,157)	43	1
2	X-Rays - Part A	(2,178)	43	2
3	To offset cable income	(1,200)	43	3
4	To offset meal income	(3,594)	2	4
5	To offset miscellaneous income	(603)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(18,732)		49

Summary A

12/31/2005

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	TOTALS
												(to Sch V, col.7)
1	Dietary	0	3,583	0	0	0	0	0	0	0	0	3,583
2	Food Purchase	(3,594)	114	0	14	0	0	0	0	0	0	(3,466)
3	Housekeeping	0	81	0	3	0	0	0	0	0	0	84
4	Laundry	0	6	0	0	0	0	0	0	0	0	6
5	Heat and Other Utilities	0	546	0	46	0	0	0	0	0	0	592
6	Maintenance	0	4,699	0	1,001	0	0	0	0	0	0	5,700
7	Other (specify):*	0	1,023	0	196	0	0	0	0	0	0	1,219
8	TOTAL General Services	(3,594)	10,052	0	1,260	0	0	0	0	0	0	7,718
9	B. Health Care and Programs											
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0
10	Nursing and Medical Records	0	5,926	0	15,853	0	0	0	0	0	0	21,779
10a	Therapy	0	4	0	0	0	0	0	0	0	0	4
11	Activities	0	0	0	11	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0
15	Other (specify):*	0	821	0	3,775	0	0	0	0	0	0	4,596
16	TOTAL Health Care and Programs	0	6,751	0	19,639	0	0	0	0	0	0	26,390
17	C. General Administration											
17	Administrative	0	(144,622)	0	0	0	0	0	0	0	0	(144,622)
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0
19	Professional Services	0	7,368	0	6,221	0	0	0	0	0	0	13,589
20	Fees, Subscriptions & Promotions	0	3,354	0	598	0	0	0	0	0	0	3,952
21	Clerical & General Office Expenses	(603)	0	32,745	41,908	0	0	0	0	0	0	74,050
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0
23	Inservice Training & Education	0	0	532	549	0	0	0	0	0	0	1,081
24	Travel and Seminar	0	0	730	315	0	0	0	0	0	0	1,045
25	Other Admin. Staff Transportation	0	0	2,654	1,985	0	0	0	0	0	0	4,639
26	Insurance-Prop.Liab.Malpractice	0	0	969	1,423	0	0	0	0	0	0	2,392
27	Other (specify):*	0	0	7,285	9,414	0	0	0	0	0	0	16,699
28	TOTAL General Administration	(603)	(133,900)	44,915	62,413	0	0	0	0	0	0	(27,175)
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,197)	(117,097)	44,915	83,312	0	0	0	0	0	0	6,933

Facility Name & ID Number Flora Rehabilitation & Health Care Cente# 0046615Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,583	\$ 3,583	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	114	114	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	81	81	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	6	6	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	546	546	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	4,699	4,699	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,023	1,023	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,926	5,926	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	4	4	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	821	821	10
11	V	17	Administrative	170,000	Petersen Health Care, Inc.	100.00%	25,378	(144,622)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	7,368	7,368	12
13	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	3,354	3,354	13
14	Total			\$ 170,000			\$ 52,903	\$ * (117,097)	14

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Flora Rehabilitation & Health Care Cente # 0046615 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 32,745	\$ 32,745
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	532	532
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	730	730
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	2,654	2,654
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	969	969
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,285	7,285
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,664	4,664
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,276	6,276
23	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	589	589
24	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	144	144
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 56,588	\$ * 56,588

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Flora Rehabilitation & Health Care Cente# 0046615Report Period Beginning: 01/01/2005Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$	Petersen Health Care II, Inc.	0.00%	\$ 14	\$ 14
16	V	3 Housekeeping		Petersen Health Care II, Inc.	0.00%	3	3
17	V	5 Utilities		Petersen Health Care II, Inc.	0.00%	46	46
18	V	6 Maintenance		Petersen Health Care II, Inc.	0.00%	1,001	1,001
19	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	196	196
20	V	10 Nursing & Medical Records		Petersen Health Care II, Inc.	0.00%	15,853	15,853
21	V	11 Activities		Petersen Health Care II, Inc.	0.00%	11	11
22	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	3,775	3,775
23	V	19 Professional Services		Petersen Health Care II, Inc.	0.00%	6,221	6,221
24	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	0.00%	598	598
25	V	21 Clerical & General Office		Petersen Health Care II, Inc.	0.00%	41,908	41,908
26	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	0.00%	549	549
27	V	24 Travel and Seminar		Petersen Health Care II, Inc.	0.00%	315	315
28	V	25 Other Admin. Staff Transport		Petersen Health Care II, Inc.	0.00%	1,985	1,985
29	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care II, Inc.	0.00%	1,423	1,423
30	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	9,414	9,414
31	V	30 Depreciation		Petersen Health Care II, Inc.	0.00%	9,113	9,113
32	V	32 Interest		Petersen Health Care II, Inc.	0.00%	10,940	10,940
33	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	0.00%	29	29
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 103,394	\$ * 103,394

* Total must agree with the amount recorded on line 34 of Schedule V1

SEE ACCOUNTANTS' COMPILATION REPORT

Flora
Provider #0046615
12/31/2005

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Aledo Rehabilitation & Health Care Center	Aledo, IL
Arcola Health Care Center	Arcola, IL
Arrow Wood Estates of Rock Falls	Rock Falls, IL
Aspen Rehab & Health Care	Silvis, IL
Batavia Rehabilitation & Health Care Center	Batavia, IL
Bement Health Care Center	Bement, IL
Benton Rehabilitation & Health Care Center	Benton, IL
Bloomington Rehabilitation & Health Care Center	Bloomington, IL
Casey Health Care Center	Casey, IL
Cisne Rehabilitation & Health Care Center	Cisne, IL
Countryview Care Center of Macomb	Macomb, IL
Countryview Terrace	Louisville, IL
Decatur Rehabilitation & Health Care Center	Decatur, IL
Eastside Health & Rehabilitation Center	Pittsfield, IL
Eastview Terrace	Sullivan, IL
Effingham Rehabilitation & Health Care Center	Effingham, IL
El Paso Health Care Center	El Paso, IL
Elgin Rehabilitation & Health Care Center	South Elgin, IL
Enfield Rehabilitation & Health Care Center	Enfield, IL
Flora Health Care Center	Flora, IL
Fondulac Rehabilitation & Health Care Center	East Peoria, IL
Havana Health Care Center	Havana, IL
Ironwood Estates of Sandwich	Sandwich, IL
Jonesboro Rehabilitation & Health Care Center	Jonesboro, IL
Kewanee Care Home	Kewanee, IL
McLeansboro Rehabilitation & Health Care Center	McLeansboro, IL
Newman Rehabilitation & Health Care Center	Newman, IL
North Aurora Care Center	Aurora, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Rock Falls Rehabilitation & Health Care Center	Rock Falls, IL
Rosiclare Rehabilitation & Health Care Center	Rosiclare, IL
Royal Oaks Care Center	Kewanee, IL
Sandwich Rehabilitation & Health Care Center	Sandwich, IL
Shelbyville Rehabilitation & Health Care Center	Shelbyville, IL
Sheldon Health Care Center	Sheldon, IL
Sugar Creek Care Center	Watseka, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Timbercreek Rehabilitation & Health Care Center	Pekin, IL
Toulon Rehabilitation & Health Care Center	Toulon, IL
Tuscola Health Care Center	Tuscola, IL
Vandalia Rehabilitation & Health Care Center	Vandalia, IL
Watsika Rehabilitation & Health Care Center	Watsika, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
----------------------------	---------------

Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL
Riverview Estates of Havana	Havana, IL
Simple Blessings	Casey, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
Petersen Health Operations, L.L.C.	Peoria, IL	Management/Bookkeeping
R/LP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	2	4.4%	Salary	\$ 25,378	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 25,378		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Petersen Health Care, Inc.
 Street Address 830 West Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	683,169	46	\$ 82,166	\$ 81,693	29,789	\$ 3,583	1
2	2	Food	Patient Days	683,169	46	2,606		29,789	114	2
3	3	Housekeeping	Patient Days	683,169	46	1,857		29,789	81	3
4	4	Laundry	Patient Days	683,169	46	144		29,789	6	4
5	5	Utilities	Patient Days	683,169	46	12,513		29,789	546	5
6	6	Maintenance	Patient Days	683,169	46	107,775	81,080	29,789	4,699	6
7	7	Mgmt. Allocation of Benefits	Patient Days	683,169	46	23,459		29,789	1,023	7
8	10	Nursing and Medical Records	Patient Days	683,169	46	135,903	130,651	29,789	5,926	8
9	10A	Therapy	Patient Days	683,169	46	88		29,789	4	9
10	15	Mgmt. Allocation of Benefits	Patient Days	683,169	46	18,830		29,789	821	10
11	17	Administrative	Patient Days	683,169	46	582,000	582,000	29,789	25,378	11
12	19	Professional Services	Patient Days	683,169	46	168,984		29,789	7,368	12
13	20	Dues, Fees, Subs & Promos	Patient Days	683,169	46	76,921		29,789	3,354	13
14	21	Clerical & General Office	Patient Days	683,169	46	750,958	577,218	29,789	32,745	14
15	23	Inservice Training & Education	Patient Days	683,169	46	12,208		29,789	532	15
16	24	Travel & Seminar	Patient Days	683,169	46	16,731		29,789	730	16
17	25	Other Admin. Staff Transport	Patient Days	683,169	46	60,875		29,789	2,654	17
18	26	Insurance-Prop.Liab.Malp.	Patient Days	683,169	46	22,218		29,789	969	18
19	27	Mgmt. Allocation of Benefits	Patient Days	683,169	46	167,067		29,789	7,285	19
20	30	Depreciation	Patient Days	683,169	46	106,965		29,789	4,664	20
21	32	Interest	Patient Days	683,169	46	143,934		29,789	6,276	21
22	34	Rent - Facility & Grounds	Patient Days	683,169	46	13,500		29,789	589	22
23	35	Rent - Equipment & Vehicles	Patient Days	683,169	46	3,305		29,789	144	23
24										24
25	TOTALS					\$ 2,511,007	\$ 1,452,642		\$ 109,491	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Petersen Health Care II, Inc.
 Street Address 830 West Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Patient Days	241,523	7	\$ 114	\$	29,789	\$ 14	1
2	3	Housekeeping	Patient Days	241,523	7	24		29,789	3	2
3	5	Utilities	Patient Days	241,523	7	370		29,789	46	3
4	6	Maintenance	Patient Days	241,523	7	8,117	6,500	29,789	1,001	4
5	7	Mgmt. Allocation of Benefits	Patient Days	241,523	7	1,587		29,789	196	5
6	10	Nursing & Medical Records	Patient Days	241,523	7	128,534	125,373	29,789	15,853	6
7	11	Activities	Patient Days	241,523	7	93		29,789	11	7
8	15	Mgmt. Allocation of Benefits	Patient Days	241,523	7	30,610		29,789	3,775	8
9	19	Professional Services	Patient Days	241,523	7	50,439		29,789	6,221	9
10	20	Dues, Fees, Subs & Promotions	Patient Days	241,523	7	4,852		29,789	598	10
11	21	Clerical & General Office	Patient Days	241,523	7	339,781	312,613	29,789	41,908	11
12	23	Inservice Training & Education	Patient Days	241,523	7	4,454		29,789	549	12
13	24	Travel & Seminar	Patient Days	241,523	7	2,551		29,789	315	13
14	25	Other Admin. Staff Transport	Patient Days	241,523	7	16,098		29,789	1,985	14
15	26	Insurance-Prop.Liab.Malp.	Patient Days	241,523	7	11,534		29,789	1,423	15
16	27	Mgmt. Allocation of Benefits	Patient Days	241,523	7	76,326		29,789	9,414	16
17	30	Depreciation	Patient Days	241,523	7	73,886		29,789	9,113	17
18	32	Interest	Patient Days	241,523	7	88,696		29,789	10,940	18
19	33	Real Estate Taxes	Patient Days	241,523	7	236		29,789	29	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 838,302	\$ 444,486		\$ 103,394	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	US Bank		X	Mortgage Loan	Varies	1/4/05	\$ 2,912,000	\$ 2,848,684	12/18/2011	0.0699	\$ 200,906	1	
2	Ford		X	Purchase Vehicle	\$608.79	10/27/04	33,137	25,972	10/27/2009	0.0390	1,281	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$608.79		\$ 2,945,137	\$ 2,874,656			\$ 202,187	9	
	B. Non-Facility Related*												
10									Home office allocation	17,216		10	
11									Amortization of loan costs	590		11	
12									Interest Income Offset	(1)		12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 17,805	14	
15	TOTALS (line 9+line14)						\$ 2,945,137	\$ 2,874,656			\$ 219,992	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Flora Rehabilitation & Health Care Center**# **0046615** Report Period Beginning: **01/01/2005** Ending: **12/31/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report	\$	44,564	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2004	\$	56,661	2
3. Under or (over) accrual (line 2 minus line 1).			\$	12,097	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	39,628	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		Home office allocation 29	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	51,754	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000		8	
		2001		9	
		2002		10	
		2003		11	
		2004	56,661	12	
Prior year tax bill information is unavailable because this property was purchased in 2004.					
Accrued real estate tax was based on a portion of the prior year real estate tax bill.					

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any over accrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Flora Rehabilitation & Health Care Center COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0046615

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE 309-691-8113 FAX #: 309-691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-23-400-014</u>	<u>22 Given St.</u>	\$ <u>55,661.00</u>	\$ <u>55,661.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>55,661.00</u>	\$ <u>55,661.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,488 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization ☒ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/AF. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	278,784	2004	\$ 129,000	1
2					2
3	TOTALS			\$ 129,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99	2004	1973	\$ 2,214,200	\$ 88,621	35	\$ 63,263	\$ (25,358)	\$ 68,535
5	Home office allocation - Building	2005		29,685			557	557	557
6									
7									
8									
9	Improvement Type**								
10	2005 Home office allocation - Land Improvements			1,716			53	53	53
11	2005 Home office allocation - Building Improvements			49			2	2	2
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,245,650	\$ 88,621		\$ 63,875	\$ (24,746)	\$ 69,147	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number: Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component/ Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 589,661	\$ 84,147	\$ 53,042	\$ (31,105)	10	\$ 64,605	71
72	Current Year Purchases	20,474	1,186	964	(222)	10	964	72
73	Fully Depreciated Assets							73
74		Home office allocation		13,165	13,165			74
75	TOTALS	\$ 610,135	\$ 85,333	\$ 67,171	\$ (18,162)		\$ 65,569	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	2005 Ford	2004	\$ 33,217	\$ 6,643	\$ 6,643		5	\$ 7,751	76
77										77
78										78
79										79
80	TOTALS			\$ 33,217	\$ 6,643	\$ 6,643			\$ 7,751	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,018,002	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 180,597	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 137,689	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (42,908)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 142,467	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column f

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		Allocated from Management Company			589			6
7	TOTAL				\$ 589			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
 This amount was calculated by dividing the total amount to be amortized N/A
 by the length of the lease N/A.

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 13,204 Description: See Attached Schedule 14A
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Flora Rehabilitation & Health Care Center

Provider # 0046615

12/31/2005

Schedule 14a

XII. RENTAL COSTS

B. Equipment-Excluding Transportation and Fixed Equipment.

Rented Item	Cost
Sewer Auger	48
Copy Machine	2,254
Air Mattresses	7,293
Compressors	227
Therapy Units	917
Oxygen Tanks	272
Respiratory Devices	447
Lift	892
Dish Machine	710
Home Office Allocation	144
Total	<u>13,204</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA _____
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefit.

(c) For in-house training programs only. Do not include fringe benefit.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities:

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist	L10a, C3	hrs	\$	3,264
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		829	53,008		829	53,008	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C3	hrs		5,410	245,697		5,410	245,697	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	L39, C2					12,971		12,971	13
14	TOTAL			\$	9,503	\$ 484,064	\$ 12,971	9,503	\$ 497,035	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Flora Rehabilitation & Health Care Center

Provider # 0046615

12/31/2005

Schedule 16a

XIV. SPECIAL SERVICES (Direct Cost)

Line 13 Other (specify):

			Outside Practitioner		
Service	Reference	Staff	Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 655,018	\$ 655,018	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	758,867	758,867	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,732	3,732	6
7	Other Prepaid Expenses	20,675	20,675	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,438,292	\$ 1,438,292	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	129,000	129,000	13
14	Buildings, at Historical Cost	2,214,200	2,243,885	14
15	Leasehold Improvements, at Historical Cost		1,765	15
16	Equipment, at Historical Cost	643,352	643,352	16
17	Accumulated Depreciation (book methods)	(198,540)	(142,467)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): <u>See Sch17a</u>	22,233	22,233	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,810,245	\$ 2,897,768	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,248,537	\$ 4,336,060	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 604,263	\$ 604,263	26
27	Officer's Accounts Payable	39,035	39,035	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,455	124,455	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,628	39,628	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	30,086	30,086	35
	Other Current Liabilities(specify):			
36	<u>See Sch17a</u>	3,190	3,190	36
37	<u>See Sch17a</u>	52,148	52,148	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 892,805	\$ 892,805	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	25,972	25,972	39
40	Mortgage Payable	2,848,684	2,848,684	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,874,656	\$ 2,874,656	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,767,461	\$ 3,767,461	46
47	TOTAL EQUITY (page 18, line 24)	\$ 481,076	\$ 568,599	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,248,537	\$ 4,336,060	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Flora Health Care Center
PROVIDER # 0046615
12/31/2005

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Long Term Assets

Other (specify):	Operating	After
		Consolidation
Goodwill	18,710	18,710
Loan Costs	3,523	3,523
Total Line 23 - Other(specify):	22,233	22,233

C. Current Liabilities

Other Current Liabilities (specify)	Operating	After
		Consolidation
Wage Garnishment	577	577
Other Withholdings	2,721	2,721
Earned Income Credit	(108)	(108)
Accrued Insurance		
Total Line 36 -(specify):	3,190	3,190

Other Current Liabilities (specify)	Operating	After
		Consolidation
Assessments	(1)	(1)
Accrued Sales Tax	130	130
Accrued Interest	16,641	16,641
Accrued Expenses - Other	35,378	35,378
Total Line 37 -(specify):	52,148	52,148

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(44,329)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (44,329)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	525,405	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 525,405	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 481,076	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,149,482	1
2	Discounts and Allowances for all Levels	323,259	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,472,741	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	839,699	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 839,699	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,594	14
15	Telephone, Television and Radio	1,200	15
16	Rental of Facility Space		16
17	Sale of Drugs	281,640	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	30,204	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 316,638	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	1	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	599	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 599	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,629,678	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	655,056	31
32	Health Care	2,163,873	32
33	General Administration	692,614	33
B. Capital Expense			
34	Ownership	448,159	34
C. Ancillary Expense			
35	Special Cost Centers	90,368	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,104,273	40
41	Income before Income Taxes (line 30 minus line 40)**	525,405	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 525,405	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Flora Rehabilitation & Health Care Center**# **0046615**Report Period Beginning: **01/01/2005**

Ending:

12/31/2005**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,664	1,664	\$ 46,167	\$ 27.74	1
2	Assistant Director of Nursing	2,196	2,196	45,071	20.52	2
3	Registered Nurses	15,105	15,105	266,787	17.66	3
4	Licensed Practical Nurses	15,878	15,978	251,613	15.75	4
5	CNAs & Orderlies	53,926	54,323	553,192	10.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,972	2,004	19,520	9.74	9
10	Activity Assistants	2,180	2,204	15,562	7.06	10
11	Social Service Worker	4,056	4,072	66,679	16.38	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,611	16.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,587	14,705	123,880	8.42	15
16	Dishwashers					16
17	Maintenance Worker	2,011	2,011	37,233	18.51	17
18	Housekeepers	12,765	12,765	86,482	6.77	18
19	Laundry	6,577	6,633	43,455	6.55	19
20	Administrator	2,080	2,080	92,714	44.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,138	4,178	41,747	9.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch20a</u>	2,548	2,548	70,619	27.72	33
34	TOTAL (lines 1 - 33)	143,763	144,546	\$ 1,795,332 *	\$ 12.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	41	\$ 1,412	L1, C3	35
36	Medical Director	Monthly	31,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	9 visits	1,124	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Rehab Consultant</u>	9	281	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	50	\$ 34,017		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name Flora Rehabilitation & Health Care Center
PROVIDER # 0046615
Period Ending 12/31/2005

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

	Hours Worked	Hours Paid	Salary	Avg Hr Wage	Cost Report Line
Care Plan Coordinator	2,516	2,516	70,245	\$ 27.92	10
Transportation	32	32	374	\$ 11.69	14
Total Line 33 - Other Health Care	2,548	2,548	\$ 70,619	\$ 27.72	

See Accountants' Compilation Report

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Jane Owens	Administrator	0%	\$ 92,714
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.			\$ 92,714
B. Administrative - Other			
Description			Amount
Management Fees (eliminated in Column 7)			\$ 170,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 170,000
C. Professional Services			
Vendor/Payee	Type		Amount
Bush, Snyder, & Associates	Legal		\$ 1,699
Altschuler, Melvoin, & Glasser LLP	Accounting		4,000
Advanced Answers on Demand Inc.	Computer		476
IVANS	Computer		334
Wabash Independent Networks	Computer		305
Cindy White	Computer		323
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.			\$ 7,137
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 40,692
Unemployment Compensation Insurance			52,164
FICA Taxes			127,807
Employee Health Insurance			48,591
Employee Meals			2,683
Illinois Municipal Retirement Fund (IMRF)*			
Employee Life Insurance			406
Employee Relations			4,607
TOTAL (agree to Schedule V, line 22, col.8)			\$ 276,950
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 995
Advertising: Employee Recruitment			352
Health Care Worker Background Check (Indicate # of checks performed 67)			940
Misc. Licenses			228
Misc. Dues			215
Allocation from Home Office			3,952
Less: Public Relations Expense			(
Non-allowable advertising			(
Yellow page advertising			(
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 6,682
G. Schedule of Travel and Seminar*			
Description			Amount
Out-of-State Travel			\$
In-State Travel			2,048
Seminar Expense			
Allocation from Home Office			1,045
Entertainment Expense			(
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 3,093

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

FACILITY NAME: Flora
PROVIDER # 0046615
12/31/2005

Schedule 21a

XIX. SUPPORT SCHEDULES

C. Professional Services

TOTAL (agree to Schedule V, line 19, column 3)	7,137
Home office allocation - Legal	139
Home office allocation - Other Professional Fees	13,450
TOTAL (agree to Schedule V, line 19, column 8)	<u>20,726</u>

See Accountants Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 6 7 8 9 10 11 12 13 Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report No
If YES, give association name and amount N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases Yes
What was the average life used for new equipment added during this period 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 13,303 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? No If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these function
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,683 Has any meal income been offset against related costs? Yes Indicate the amount \$ 3,594
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel No
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 3%
d. Have vehicle usage logs been maintained Yes **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm Yes
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in process
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fee

RECONCILIATION REPORT

11:28 AM 5/16/2006

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-95,395	equal to	-95,395	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	219,992	equal to	219,992	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	51,754	equal to	51,754	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	137,689	equal to	137,689	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	589	equal to	589	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	13,204	equal to	13,204	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	484,064	equal to	484,064	0	O.K.	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	12,971	equal to	12,971	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	655,056	equal to	655,056	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,163,873	equal to	2,163,873	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	692,614	equal to	692,614	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	448,159	equal to	448,159	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	90,368	equal to	90,368	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	54,203	equal to	54,203	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,162,830	equal to	1,233,075	-70,245	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	35,082	equal to	35,082	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	66,679	equal to	66,679	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	158,491	equal to	158,491	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	37,233	equal to	37,233	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	86,482	equal to	86,482	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	43,455	equal to	43,455	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	92,714	equal to	92,714	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	41,747	equal to	41,747	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,795,332	equal to	1,795,332	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,412	< or = to	1,412	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	31,200	< or = to	31,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,124	< or = to	1,405	-281	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	0	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	92,714	equal to	92,714	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	170,000	equal to	170,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	7,137	equal to	7,137	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	276,950	equal to	276,950	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,682	equal to	6,682	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,093	equal to	3,093	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particp. Fees	54,203	equal to	54,203	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	2,683	< or = to	2,683	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	2,683	equal to	2,683	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	7,567	equal to	7,567	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	42,885	equal to	42,885	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	2,874,656	equal to	2,874,656	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	39,628	equal to	39,628	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	129,000	equal to	129,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,245,650	equal to	2,245,650	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	643,352	equal to	643,352	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	142,467	equal to	142,467	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	481,076	equal to	481,076	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	525,405	equal to	525,405	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,248,537	equal to	4,248,537	0	O.K.	Pg17 H41		25	1	Pg17 S41	N/A	48	1

Flora Rehabilitation & Health Care Center
IDHFS Comparative Data - Per Resident Day Cost
Year Ending 12/31/2005

Enter your HSA # in next column ===== 5
Census (Pulls from Page 2) 29,789

Cost Report Line	Description	Your Facility	Average Median Cost Per Day (2003)		
			State	HSA	
1	Dietary	6.03	6.01	5.48	
2	Food Purchase	4.12	4.31	3.99	
3	Housekeeping	3.92	3.70	3.40	
4	Laundry	2.10	1.85	2.10	
5	Heat & Other Utilities	3.34	2.95	2.71	
6	Maintenance	2.61	3.01	2.55	
8	Total General Services	22.16	22.58	21.47	
10	Nursing & Medical Records	52.18	41.83	33.78	
10A	Therapy	16.25	2.10	3.47	
11	Activities	1.62	1.91	1.48	
12	Social Services	2.26	1.42	1.09	
16	Total Health Care & Programs	73.53	49.48	41.58	
17	Administration	3.96	3.36	3.60	
19	Professional Services	0.70	0.99	0.76	
21	Clerical & Gen. Office Expense	4.93	4.79	3.46	
22	Employee Benefits & PR Taxes	9.30	10.09	7.67	
24	Travel & Seminar	0.10	0.08	0.13	
26	Insurance-Property, Liability & Malpractice	2.01	2.58	2.22	
28	Total General Administrative	22.43	24.94	21.37	
29	Total Operating Expenses	118.11	98.06	88.05	
30	Depreciation	4.62	3.70	2.54	
32	Interest	7.39	2.54	1.41	
33	Real Estate Taxes	1.74	1.38	0.80	
37	Total Ownership	142.21	111.11	7.04	
	Total Operating and Ownership Cost	132.32	109.17	95.09	

Notes:

Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.

The Average Median Cost Per Day for the State and your HSA is taken from 2003 data available from the Illinois Department of Healthcare and Family Services and corresponds with the respective cost report data after final adjustments.

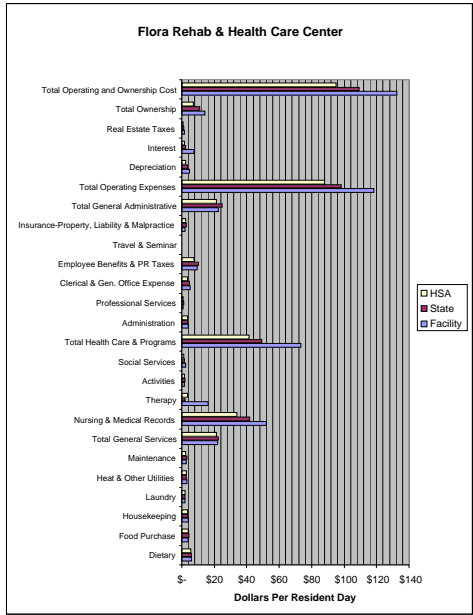
IDHFS LTC Profiles

LTC Median Per Diem Cost by HSA - 2003 Cost Reports

2003 (Run June 1, 2004)

UN-INFLATED

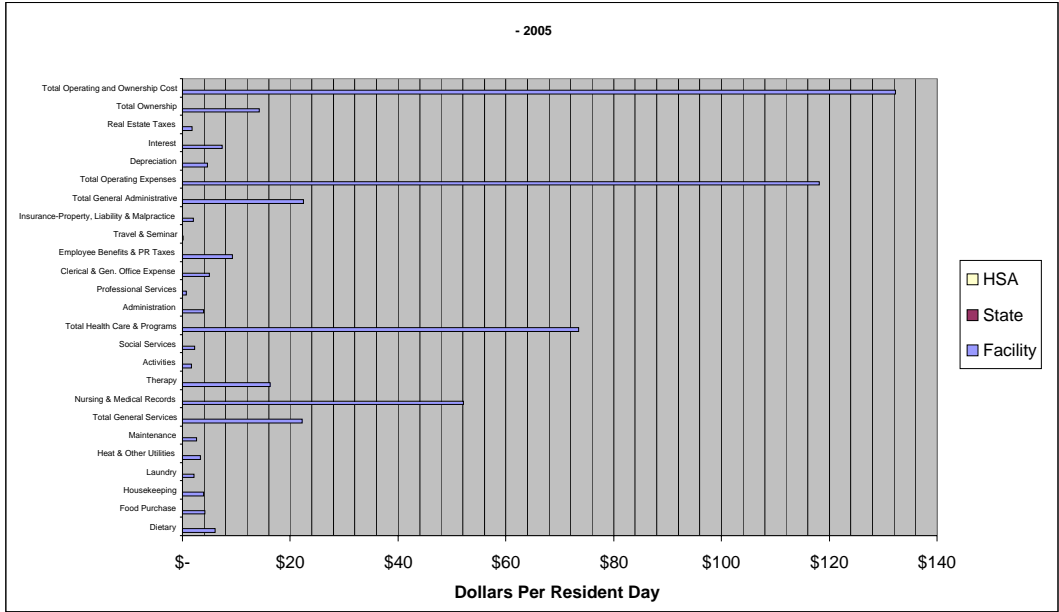
Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.01	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	21.73	17.57	31.51
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	49.49	32.10	77.23
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	22.93	16.95	39.14
29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	94.71	69.40	142.56
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	TOTAL OWNERSHIP	11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	8.39	3.76	23.58
	TOTAL OPERATING & OWNERSHIP CC	109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	103.10	73.16	166.14



Cost Report Line	Description	2005			2004			2003			2002		
		Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA
1	Dietary	6.03	-	-	#DIV/0!	-	-	#DIV/0!	6.10	5.70	#DIV/0!	6.01	5.60
2	Food Purchase	4.12	-	-	#DIV/0!	-	-	#DIV/0!	4.31	4.11	#DIV/0!	4.27	4.09
3	Housekeeping	3.92	-	-	#DIV/0!	-	-	#DIV/0!	3.70	3.61	#DIV/0!	3.65	3.48
4	Laundry	2.10	-	-	#DIV/0!	-	-	#DIV/0!	1.85	2.13	#DIV/0!	1.90	2.23
5	Heat & Other Utilities	3.34	-	-	#DIV/0!	-	-	#DIV/0!	2.95	2.95	#DIV/0!	2.71	2.73
6	Maintenance	2.61	-	-	#DIV/0!	-	-	#DIV/0!	3.01	2.82	#DIV/0!	2.99	2.92
8	Total General Services	22.16	-	-	#DIV/0!	-	-	#DIV/0!	22.58	21.73	#DIV/0!	22.09	22.04
10	Nursing & Medical Records	52.18	-	-	#DIV/0!	-	-	#DIV/0!	41.83	42.15	#DIV/0!	40.68	41.16
10A	Therapy	16.25	-	-	#DIV/0!	-	-	#DIV/0!	2.10	2.24	#DIV/0!	1.85	2.27
11	Activities	1.62	-	-	#DIV/0!	-	-	#DIV/0!	1.91	1.54	#DIV/0!	1.88	1.60
12	Social Services	2.26	-	-	#DIV/0!	-	-	#DIV/0!	1.42	1.27	#DIV/0!	1.44	1.32
16	Total Health Care & Programs	73.53	-	-	#DIV/0!	-	-	#DIV/0!	49.48	49.49	#DIV/0!	47.55	47.76
17	Administration	3.96	-	-	#DIV/0!	-	-	#DIV/0!	3.36	3.17	#DIV/0!	3.39	3.54
19	Professional Services	0.70	-	-	#DIV/0!	-	-	#DIV/0!	0.99	0.77	#DIV/0!	0.98	0.72
21	Clerical & Gen. Office Expense	4.93	-	-	#DIV/0!	-	-	#DIV/0!	4.79	4.25	#DIV/0!	4.58	4.31
22	Employee Benefits & PR Taxes	9.30	-	-	#DIV/0!	-	-	#DIV/0!	10.09	9.08	#DIV/0!	9.63	8.44
24	Travel & Seminar	0.10	-	-	#DIV/0!	-	-	#DIV/0!	0.08	0.07	#DIV/0!	0.09	0.09
26	Insurance-Property, Liability & Malpractice	2.01	-	-	#DIV/0!	-	-	#DIV/0!	2.58	2.61	#DIV/0!	2.19	2.03
28	Total General Administrative	22.43	-	-	#DIV/0!	-	-	#DIV/0!	24.94	22.93	#DIV/0!	23.47	21.93
29	Total Operating Expenses	118.11	-	-	#DIV/0!	-	-	#DIV/0!	98.06	94.71	#DIV/0!	94.39	91.33
30	Depreciation	4.62	-	-	#DIV/0!	-	-	#DIV/0!	3.70	3.38	#DIV/0!	3.53	3.04
32	Interest	7.39	-	-	#DIV/0!	-	-	#DIV/0!	2.54	1.50	#DIV/0!	2.73	1.54
33	Real Estate Taxes	1.74	-	-	#DIV/0!	-	-	#DIV/0!	1.38	1.11	#DIV/0!	1.30	1.03
37	Total Ownership	14.21	-	-	#DIV/0!	-	-	#DIV/0!	11.11	8.39	#DIV/0!	11.44	10.00
	Total Operating and Ownership Cost	132.32	-	-	#DIV/0!	-	-	#DIV/0!	103.10	103.10	#DIV/0!	105.83	101.30

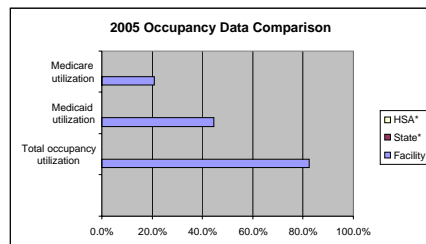
Notes:
Your Facility data is from page 3, column 8 of each of your respective Medicaid cost reports, divided by the respective annual census.

The 2005, 2004, 2003 & 2002 Median Cost Per Day, for the State and your HSA is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.



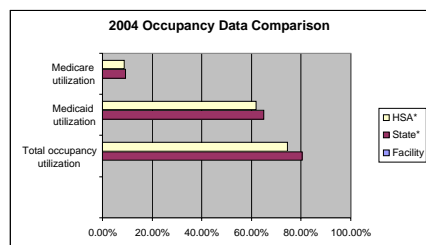
2005

Your Facility	State*	HSA*
Total occupancy utilization	82.44%	0.00%
Medicaid utilization	44.63%	0.00%
Medicare utilization	20.94%	0.00%
Private pay percent utilization	16.87%	N/A
Capacity in Patient Days	36,135	N/A
Census days of service provided	29,789	N/A



2004

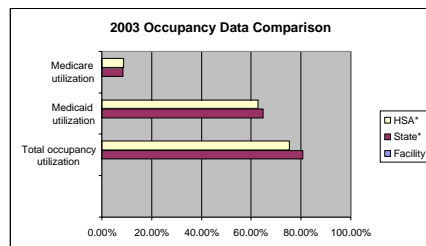
Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.50%
Medicaid utilization	#DIV/0!	65.00%
Medicare utilization	#DIV/0!	9.40%
Private pay percent utilization	#DIV/0!	N/A
Capacity in Patient Days	N/A	N/A
Census days of service provided	N/A	N/A



* State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

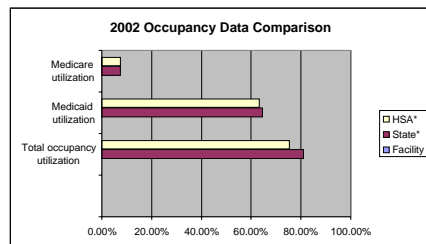
2003

Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.80%
Medicaid utilization	#DIV/0!	64.80%
Medicare utilization	#DIV/0!	8.50%
Private pay percent utilization	#DIV/0!	N/A
Capacity in Patient Days	N/A	N/A
Census days of service provided	N/A	N/A

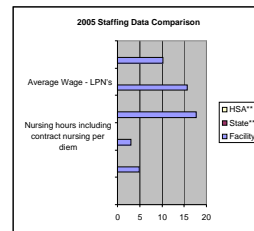


2002

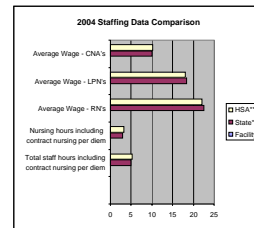
Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.90%
Medicaid utilization	#DIV/0!	64.50%
Medicare utilization	#DIV/0!	7.40%
Private pay percent utilization	#DIV/0!	N/A
Capacity in Patient Days	N/A	N/A
Census days of service provided	N/A	N/A



2005			
Your			
Facility	State**	HSA**	
Total staff hours including contract nursing per diem	4.85	0.00	0.00
Nursing hours including contract nursing per diem	3.00	0.00	0.00
Average Wage - RN's	17.66	0.00	0.00
Average Wage - LPN's	15.75	0.00	0.00
Average Wage - CNA's	10.18	0.00	0.00

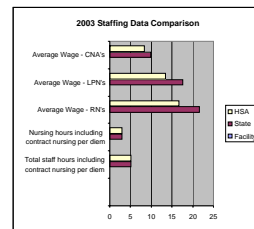


2004			
Your			
Facility	State**	HSA**	
Total staff hours including contract nursing per diem	5.00	5.30	
Nursing hours including contract nursing per diem	3.00	3.20	
Average Wage - RN's	22.54	22.05	
Average Wage - LPN's	18.40	18.02	
Average Wage - CNA's	10.02	10.13	

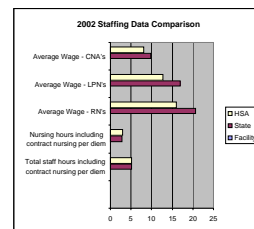


** State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

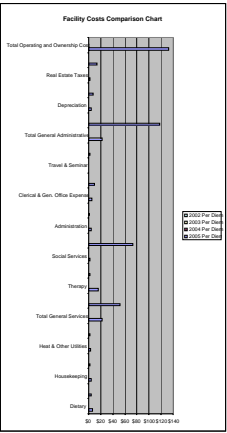
2003			
Your			
Facility	State	HSA	
Total staff hours including contract nursing per diem	5.10	5.10	
Nursing hours including contract nursing per diem	2.90	3.00	
Average Wage - RN's	21.56	16.66	
Average Wage - LPN's	17.64	13.36	
Average Wage - CNA's	9.91	8.28	



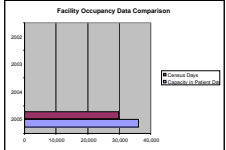
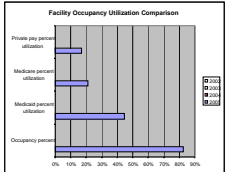
2002			
Your			
Facility	State	HSA	
Total staff hours including contract nursing per diem	5.20	5.10	
Nursing hours including contract nursing per diem	2.80	2.90	
Average Wage - RN's	20.69	16.06	
Average Wage - LPN's	16.89	12.75	
Average Wage - CNA's	9.73	8.08	



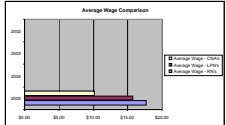
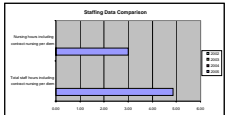
Report Line	Description	Year			
		2003	2004	2005	2006
		Per Show	Per Show	Per Show	Per Show
1	Dietary	4.03	4500.00	4500.00	4500.00
2	Food Purchase	4.12	4500.00	4500.00	4500.00
3	Housekeeping	3.62	4500.00	4500.00	4500.00
4	Landscaping	1.10	4500.00	4500.00	4500.00
5	Heat & Other Utilities	2.34	4500.00	4500.00	4500.00
6	Maintenance	2.65	4500.00	4500.00	4500.00
8	Total General Services	22.14	4500.00	4500.00	4500.00
10	Nursing & Medical Records	52.14	4500.00	4500.00	4500.00
10A	Therapy	16.25	4500.00	4500.00	4500.00
11	Activities	1.62	4500.00	4500.00	4500.00
12	Social Services	2.24	4500.00	4500.00	4500.00
16	Total Health Care & Programs	75.35	4500.00	4500.00	4500.00
17	Administration	2.64	4500.00	4500.00	4500.00
19	Professional Services	6.79	4500.00	4500.00	4500.00
21	Child & Gen. Office Expense	4.93	4500.00	4500.00	4500.00
22	Employee Benefits & P.R. Taxes	4.50	4500.00	4500.00	4500.00
24	Travel & Lodging	0.16	4500.00	4500.00	4500.00
26	Insurance-Property, Liability & Malpractice	2.00	4500.00	4500.00	4500.00
28	Total General Administration	22.67	4500.00	4500.00	4500.00
29	Total Operating Expenses	110.11	4500.00	4500.00	4500.00
30	Depreciation	6.62	4500.00	4500.00	4500.00
32	Interest	7.14	4500.00	4500.00	4500.00
33	Real Estate Taxes	1.74	4500.00	4500.00	4500.00
37	Total Ownership	16.23	4500.00	4500.00	4500.00
Total Operating and Ownership Cost		132.12	4500.00	4500.00	4500.00



	Facility 2003	Facility 2004	Facility 2005	Facility 2006
Occupancy percent	82.44%	4500.00	4500.00	4500.00
Medicaid percent utilization	44.63%	4500.00	4500.00	4500.00
Medicare percent utilization	20.34%	4500.00	4500.00	4500.00
Private pay percent utilization	34.87%	4500.00	4500.00	4500.00
Capacity in Patient Days	36,100	0	0	0
Census Days	36,786	0	0	0



	Facility 2003	Facility 2004	Facility 2005	Facility 2006
Total staff hours including contract nursing per day	4.86	0.00	0.00	0.00
Nursing hours including contract nursing per show	0.00	0.00	0.00	0.00
Average Wage - BNY	17.86	0.00	0.00	0.00
Average Wage - LPRN	15.75	0.00	0.00	0.00
Average Wage - CNNA	16.16	0.00	0.00	0.00



	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	158,491	16,253	1,412	176,156	0	176,156	3,583	179,739
2. Food Purchase	0	128,769	0	128,769	0	128,769	-6,149	122,620
3. Housekeeping	86,482	30,185	0	116,667	0	116,667	84	116,751
4. Laundry	43,455	19,215	0	62,670	0	62,670	6	62,676
5. Heat and Other Utilities	0	0	98,838	98,838	0	98,838	592	99,430
6. Maintenance	37,233	33,183	1,540	71,956	0	71,956	5,700	77,656
7. Other (specify)*	0	0	0	0	0	0	1,219	1,219
8. Total General Services	325,661	227,605	101,790	655,056	0	655,056	5,035	660,091
9. Medical Director	0	0	31,200	31,200	0	31,200	0	31,200
10. Nursing & Medical Records	1,233,075	298,173	1,405	1,532,653	0	1,532,653	21,779	1,554,432
10a. Therapy	0	0	484,064	484,064	0	484,064	4	484,068
11. Activities	35,082	13,228	0	48,310	0	48,310	11	48,321
12. Social Services	66,679	593	0	67,272	0	67,272	0	67,272
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	374	0	0	374	0	374	0	374
15. Other (specify)*	0	0	0	0	0	0	4,596	4,596
16. Total Health Care & Programs	1,335,210	311,994	516,669	2,163,873	0	2,163,873	26,390	2,190,263
17. Administrative	92,714	0	170,000	262,714	0	262,714	-144,622	118,092
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	7,137	7,137	0	7,137	13,589	20,726
20. Fees, Subscriptions & Promotion	0	0	2,730	2,730	0	2,730	3,952	6,682
21. Clerical & General Office	41,747	8,940	22,144	72,831	0	72,831	74,050	146,881
22. Employee Benefits & Payroll	0	0	274,267	274,267	0	274,267	2,683	276,950
23. Inservice Training & Education	0	0	525	525	0	525	1,081	1,606
24. Travel and Seminar	0	0	2,048	2,048	0	2,048	1,045	3,093
25. Other Admin. Staff Trans	0	0	12,942	12,942	0	12,942	4,639	17,581
26. Insurance-Prop.Liab.Malpractice	0	0	57,420	57,420	0	57,420	2,392	59,812
27. Other (specify)*	0	0	0	0	0	0	16,699	16,699
28. Total General Adminis	134,461	8,940	549,213	692,614	0	692,614	-24,492	668,122
29. Total General Administrative	1,795,332	548,539	1,167,672	3,511,543	0	3,511,543	6,933	3,518,476
30. Depreciation	0	0	180,597	180,597	0	180,597	-42,908	137,689
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	202,777	202,777	0	202,777	17,215	219,992
33. Real Estate	0	0	51,725	51,725	0	51,725	29	51,754
34. Rent - Facility & Grounds	0	0	0	0	0	0	589	589
35. Rent - Equipment & Vehicles	0	0	13,060	13,060	0	13,060	144	13,204
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	448,159	448,159	0	448,159	-24,931	423,228
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	12,971	0	12,971	0	12,971	0	12,971
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	54,203	54,203	0	54,203	0	54,203
43. Other (specify):*	0	0	77,397	77,397	0	77,397	-77,397	0
44. Total Special Cost Ce	0	12,971	131,600	144,571	0	144,571	-77,397	67,174
45. Grand Total	1,795,332	561,510	1,747,431	4,104,273	0	4,104,273	-95,395	4,008,878

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	655,018	655,018
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	758,867	758,867
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	3,732	3,732
7. Other Prepaid Expenses	20,675	20,675
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,438,292	1,438,292
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	129,000	129,000
14. Buildings, at Historical Cost	2,214,200	2,243,885
15. Leasehold Improvements, Historical Cost	0	1,765
16. Equipment, at Historical Cost	643,352	643,352
17. Accumulated Depreciation (book methods)	-198,540	-142,467
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	22,233	22,233
24. Total Long-Term Assets	2,810,245	2,897,768
25. Total Assets	4,248,537	4,336,060
CURRENT LIABILITIES		
26. Accounts Payable	604,263	604,263
27. Officer's Accounts Payable	39,035	39,035
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	124,455	124,455
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	39,628	39,628
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	30,086	30,086
36. Other Current Liabilities (specify):	3,190	3,190
37. Other Current Liabilities (specify):	52,148	52,148
38. Total Current Liabilities	892,805	892,805
LONG TERM LIABILITES		
39. Long-Term Notes Payable	25,972	25,972
40. Mortgage Payable	2,848,684	2,848,684
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	2,874,656	2,874,656
46. Total Liabilities	3,767,461	3,767,461
47. Total Equity	481,076	568,599
48. Total Liabilities and Equity	4,248,537	4,336,060

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,149,482
2. Discounts and Allowances for all Levels	323,259
Subtotal - Inpatient Care	3,472,741
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	839,699
7. Oxygen	0
Subtotal - Ancillary Revenue	839,699
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	3,594
15. Telephone, Television, and Radio	1,200
16. Rental of Facility Space	0
17. Sale of Drugs	281,640
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	30,204
22. Laundry	0
Subtotal - Other Operating Revenue	316,638
24. Contributions	0
25. Interest and Other Investments Income	1
Subtotal - Non-Operating Revenue	1
27. Other Revenue (specify):	0
28. Other Revenue (specify):	599
Subtotal - Other Revenue	599
30. Total Revenue	4,629,678
31. General Services	655,056
32. Health Care	2,163,873
33. General Administration	692,614
34. Ownership	448,159
35. Special Cost Centers	90,368
35. Provider Participation Fee	54,203
37. Other	0
40. Total Expenses	4,104,273
41. Income Before Income Taxes	525,405
42. Income Taxes	0
43. Net Income or Loss for the Year	525,405

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LTC Median Per Diem Cost by HSA - 2005 Cost Reports
2005 (Run June 1, 2004)

UN-INFLATED

Cost Report	29,789
<u>Line</u>	<u>Description</u>
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
30	Depreciation
32	Interest
33	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

Total staff hours including contract nurses per diem
Nursing hours including contract nurses per diem
RN
LPN
CNA
DON
ADON

State-Wide

1 2 3 4 5 6 7 8 9 10

Average Occupancy
Medicaid Utilization
Medicare Utilization

State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11	

LTC Median Per Diem Cost by HSA - 2004 Cost Reports
2004 (Run June 1, 2004)

UN-INFLATED

Cost Report	General
<u>Line</u>	<u>Description</u>
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
30	Depreciation
32	Interest
33	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

	State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
		1	2	3	4	5	6	7	8	9	10	11
Total staff hours including contract nurses per diem	5.00	5.30	5.30	5.30	5.30	5.10	4.80	4.80	4.80	5.10	5.30	5.20
Nursing hours including contract nurses per diem	3.00	3.20	3.20	3.30	3.20	3.10	2.80	2.80	2.80	3.10	3.20	3.10
LPN	22.54	22.05	20.73	19.72	20.73	17.47	25.72	25.72	25.72	23.44	22.05	20.42
RN	18.4	18.02	17.23	15.4	17.23	13.82	21.06	21.06	21.06	19.09	18.02	17.13
CRN	10.03	10.13	10.05	9.32	10.03	8.4	10.51	10.52	10.52	10.43	10.13	9.63
DON	28.97	27.35	25.17	23.86	25.17	22.23	34.39	34.39	34.39	34.39	27.35	25.97
ADON	25.23	23.98	21.85	19.41	21.85	19.13	28.74	28.74	28.74	26.68	23.98	23.77

	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Average Occupancy	80.50%	80.70%	80.40%	78.10%	80.40%	74.40%	81.80%	81.80%	81.80%	82.90%	80.70%	78.20%
Medicaid Utilization	65.00%	57.00%	56.70%	58.50%	56.70%	61.80%	70.60%	70.60%	70.60%	64.50%	57.00%	60.60%
Medicare Utilization	9.40%	7.70%	8.90%	9.30%	8.90%	8.80%	9.90%	9.90%	9.90%	10.30%	7.00%	8.90%

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004)

UN-INFLATED

Flora
Rehabilitati
on & Health
Care Center

Flora
Rehabilit
ation &
Health
Care Center

2003
Census

Cost Report Line	Description	State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	10th %	90th %
			1	2	3	4	5	6	7	8	9	10		
1	Dietary	6.10	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	1.92	5.12
8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	17.57	31.51
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	32.10	77.23
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	16.95	39.14
29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	69.40	142.56
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	-	4.85
37	TOTAL OWNERSHIP	11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	3.76	23.58
	TOTAL OPERATING & OWNERSHIP COST	109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	73.16	166.14

Cost Report Line	Description	10th %	90th %
1	Dietary	4.13	9.81
2	Food Purchase	3.36	6.04
3	Housekeeping	2.48	5.80
4	Laundry	0.91	3.14
5	Heat & Other Utilities	2.05	4.25
6	Maintenance	1.92	5.12
8	TOTAL GENERAL SERVICES	17.57	31.51
10	Nursing & Medical Records	27.25	64.47
10A	Therapy	-	10.55
11	Activities	1.06	3.45
12	Social Services	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	32.10	77.23
17	Administration	1.71	7.21
19	Professional Services	0.07	3.44
21	Clerical & Gen. Office Expense	2.49	10.78
22	Employee Benefits & PR Taxes	6.33	19.34
24	Travel & Seminar	-	0.43
26	Insurance-Property, liability & Malpractice	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	16.95	39.14
29	TOTAL OPERATING EXPENSES	69.40	142.56
30	Depreciation	1.01	8.43
32	Interest	-	11.53
33	Real Estate Taxes	-	4.85
37	TOTAL OWNERSHIP	3.76	23.58
	TOTAL OPERATING & OWNERSHIP COST	73.16	166.14

Average Wage Data Table

State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11
Total staff hours including contract nurses per diem	5.10	5.30	5.30	5.00	5.30	5.10	4.90	4.90	4.90	5.10	5.30
Nursing hours including contract nurses per diem	2.90	3.20	3.10	3.10	3.10	3.00	2.70	2.70	3.00	3.20	3.10
RN	21.56	21.14	19.99	18.79	19.99	16.66	24.55	24.55	22.85	21.14	20.33
LPN	17.64	17.65	16.41	14.79	16.41	13.36	20.23	20.23	18.67	17.65	16.45
CNA	9.91	10.11	9.89	9.19	9.89	8.28	10.44	10.44	10.54	10.11	9.76
DON	27.82	26.67	24.49	23.07	24.49	20.82	33.29	33.29	29.65	26.67	24.62
ADON	24.39	22.67	21.12	19.67	21.12	18.73	27.45	27.45	26.14	22.67	22.50

2003 - Staffing and Occupancy Data

State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11
Average Occupancy	80.80%	80.80%	80.60%	79.90%	80.60%	75.20%	82.00%	82.00%	81.60%	80.80%	77.30%
Medicaid Utilization	64.80%	56.40%	57.70%	59.60%	57.70%	62.80%	70.00%	70.00%	70.00%	64.30%	59.30%
Medicare Utilization	8.50%	7.50%	7.50%	7.70%	7.50%	8.70%	9.10%	9.10%	9.10%	9.30%	8.00%

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2002 Cost Reports
2002 (Run June 1, 2004)

UN-INFLATED

Cost Report	State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	10th %	90th %
Line	Description	1	2	3	4	5	6	7	8	9	10	11		
1	Dietary	6.01	7.28	6.51	5.36	6.51	5.48	5.92	5.92	5.83	7.28	5.60	4.17	9.77
2	Food Purchase	4.27	4.52	4.40	4.15	4.40	3.99	4.31	4.31	4.31	4.11	4.52	3.29	5.90
3	Housekeeping	3.65	3.84	3.56	3.05	3.56	3.25	4.13	4.13	3.89	3.84	3.48	2.51	5.63
4	Laundry	1.90	2.15	2.01	1.72	2.01	2.09	1.67	1.67	1.58	2.15	2.23	1.10	3.13
5	Heat & Other Utilities	2.71	2.84	2.76	2.75	2.76	2.54	2.67	2.67	2.72	2.84	2.73	1.89	4.03
6	Maintenance	2.99	3.41	2.96	2.91	2.96	2.48	3.16	3.16	2.90	3.41	2.92	1.95	5.11
8	TOTAL GENERAL SERVICES	22.09	24.39	22.49	20.85	22.49	20.47	22.71	22.71	22.66	24.39	22.04	17.19	30.80
10	Nursing & Medical Records	40.68	42.79	42.10	37.44	42.10	33.35	43.96	43.96	43.84	42.79	41.16	26.11	62.04
10A	Therapy	1.85	1.90	2.38	2.86	2.38	1.81	1.54	1.54	3.02	1.90	2.27	-	10.03
11	Activities	1.88	2.12	1.89	1.50	1.89	1.37	2.23	2.23	2.10	2.12	1.60	1.13	3.39
12	Social Services	1.44	1.46	1.50	1.08	1.50	1.13	1.61	1.61	1.32	1.46	1.32	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	47.55	50.19	49.32	44.36	49.32	39.56	50.57	50.57	52.75	50.19	47.76	31.31	74.79
17	Administration	3.39	3.49	3.30	3.27	3.30	3.61	3.39	3.39	3.20	3.49	3.54	1.65	6.84
19	Professional Services	0.98	1.00	0.76	0.88	0.76	0.98	1.05	1.05	1.19	1.00	0.72	0.07	2.93
21	Clerical & Gen. Office Expense	4.58	4.07	4.40	3.67	4.40	3.47	5.75	5.75	4.19	4.07	4.31	2.36	10.72
22	Employee Benefits & PR Taxes	9.63	10.11	10.26	8.28	10.26	7.80	10.26	10.26	9.30	10.11	8.44	6.22	17.51
24	Travel & Seminar	0.09	0.12	0.10	0.09	0.10	0.16	0.06	0.06	0.03	0.12	0.09	-	0.37
26	Insurance-Property, liability & Malpractice	2.19	1.93	1.97	1.87	1.97	2.00	2.46	2.46	2.40	1.93	2.03	0.83	3.92
28	TOTAL GENERAL ADMINISTRATIVE	23.47	23.64	24.80	21.32	24.80	20.28	25.17	25.17	23.10	23.64	21.93	16.13	36.02
29	TOTAL OPERATING EXPENSES	94.39	99.26	97.46	85.50	97.46	82.47	99.35	99.35	97.86	99.26	91.33	67.15	138.58
30	Depreciation	3.53	3.13	3.86	3.26	3.86	2.41	4.18	4.18	3.94	3.13	3.04	0.73	8.09
32	Interest	2.73	2.84	2.05	2.60	2.05	1.55	4.55	4.55	2.14	2.84	1.54	-	12.86
33	Real Estate Taxes	1.30	0.77	0.88	0.93	0.88	0.72	3.17	3.17	1.29	0.77	1.03	-	5.05
37	TOTAL OWNERSHIP	11.44	9.19	9.85	8.76	9.85	6.52	15.35	15.35	11.40	9.19	10.00	3.55	24.50
	TOTAL OPERATING & OWNERSHIP COST	105.83	108.45	107.31	94.26	107.31	88.99	114.70	114.70	109.26	108.45	101.30	70.70	163.08

Cost Report	2002 Costs	2002 Census
Line	Description	
1	Dietary	
2	Food Purchase	
3	Housekeeping	
4	Laundry	
5	Heat & Other Utilities	
6	Maintenance	
8	TOTAL GENERAL SERVICES	
10	Nursing & Medical Records	
10A	Therapy	
11	Activities	
12	Social Services	
16	TOTAL HEALTH CARE & PROGRAMS	
17	Administration	
19	Professional Services	
21	Clerical & Gen. Office Expense	
22	Employee Benefits & PR Taxes	
24	Travel & Seminar	
26	Insurance-Property, liability & Malpractice	
28	TOTAL GENERAL ADMINISTRATIVE	
29	TOTAL OPERATING EXPENSES	
30	Depreciation	
32	Interest	
33	Real Estate Taxes	
37	TOTAL OWNERSHIP	
	TOTAL OPERATING & OWNERSHIP COST	

2002 - Average Wage Data Table

State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11
Total staff hours including contract nursing per diem	5.20	5.50	5.40	5.00	5.40	5.10	5.00	5.00	4.90	5.50	5.30
Nursing hours including contract nurses per diem	2.80	3.10	3.10	3.00	3.10	2.90	2.60	2.60	2.60	3.10	3.00
RN	20.69	20.12	19.18	18.37	19.18	16.06	23.49	23.49	23.49	21.31	19.45
LPN	16.89	17.04	15.72	14.33	15.72	12.75	19.39	19.39	19.39	17.96	15.69
CNA	9.73	10.05	9.65	9.09	9.65	8.08	10.28	10.28	10.28	10.39	10.05
DON	26.38	24.75	22.98	22.48	22.98	20.02	31.78	31.78	31.78	28.56	23.68
ADON	23.27	21.44	20.51	18.93	20.51	17.26	26.34	26.34	26.34	24.33	21.27

2002 - Staffing and Occupancy Data

State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11
Average Occupancy	80.90%	79.60%	81.90%	80.30%	81.90%	75.30%	82.20%	82.20%	82.20%	79.60%	76.60%
Medicaid Utilization	64.50%	55.50%	56.10%	58.50%	56.10%	63.30%	69.90%	69.90%	66.70%	55.50%	60.90%
Medicare Utilization	7.40%	6.80%	7.20%	6.10%	7.20%	7.40%	7.70%	7.70%	8.20%	6.80%	7.00%